Anthem Blue Cross
City of Riverside: Modified PPO and BC PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/ca or by calling 1-800-888-8288.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PPO providers **$0** For Non-PPO providers **$250** individual / **$750** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$500** deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained (waived for emergency admission). **$25** per visit for emergency room services (waived if admitted directly from ER).	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	For PPO providers **$1,000** per member For Non-PPO providers **$3,000** per member	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, amounts related to a transplant unrelated donor search, balance-billed charges, and health care this plan doesn't cover. Tier 4 prescription drug coinsurance will accrue to a maximum of **$3,500** per member per year.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.

Questions: Call **1-800-888-8288** or visit us at **www.anthem.com/ca**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.anthem.com/ca** or call **1-800-888-8288** to request a copy.

Does this plan use a network of providers?	Yes. For a list of **in-network providers**, see www.anthem.com/ca or call 1-800-888-8288	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **PPO providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	30% coinsurance	Deductible waived for PPO provider.
	Specialist visit	$15/visit	30% coinsurance	Deductible waived for PPO provider.
	Other practitioner office visit	10% coinsurance	30% coinsurance	Chiropractic care limited to $25/visit and 24 visits per calendar year. Acupuncture limited to $30/visit and 12 visits per calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No Charge	30% coinsurance	Non-PPO benefit limited to $20/exam, and $12/immunization for birth to age 6. Not Covered for members 7 years old and older.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.WLPCSC@express-scripts.com	Generic drugs	$10/prescription retail and home delivery	Full retail price, and submit claim form for reimbursement. We will reimburse 50% of the remaining maximum allowed amount less any pharmacy deductible (if applicable), the above retail pharmacy copay and costs in excess of the maximum allowed amount.	Retail and specialty pharmacy are a 30 day supply. Home delivery is a 90 day supply. Certain specialty pharmacy drugs must be obtained through the specialty pharmacy program. Tier 4 prescription drug coinsurance will accrue to a maximum of $3,500 per member per year not including the pharmacy deductible.
	Preferred brand drugs	$25/prescription retail, after $100 Ded $50/prescription home delivery		
	Non-preferred brand drugs	$40/prescription retail, after $100 Ded $80/prescription home delivery		
	Specialty drugs	20% coinsurance; maximum $150 copay per fill retail, maximum $300 copay per fill home delivery		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Certain services are subject to utilization review; waived for emergency admissions. Ambulatory Surgical Centers Non-PPO benefit limited to $350/admit.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Physician/surgeon fees	10% coinsurance	30% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	$25 deductible waived if admitted inpatient.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO.
	Urgent care	$15/visit	30% coinsurance	Deductible waived for PPO provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Subject to utilization review.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15/visit for physician visits, 10% coinsurance for other services	30% coinsurance	Deductible waived for outpatient physician visits for PPO provider. Facility-based care is subject to utilization review; waived for emergency admissions. Outpatient physician visits for Behavioral Health treatment subject to pre-service review.
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	
	Substance use disorder outpatient services	$15/visit for physician visits, 10% coinsurance for other services	30% coinsurance	
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Prenatal and postnatal care	$15/visit	30% coinsurance	Deductible waived for PPO provider.
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	Refer to the Physician and Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Subject to utilization review. Limited to 100 visits per calendar year.
	Rehabilitation services	10% coinsurance	30% coinsurance	Limited to $25/visit. Physical Therapy, Physical Medicine and Occupational Therapy, limited to 24 visits/calendar year.
	Habilitation services	10% coinsurance	30% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	10% coinsurance	30% coinsurance	Subject to utilization review. Limited to 100 days per calendar year.
	Durable medical equipment	10% coinsurance	30% coinsurance	May be subject to utilization review.
	Hospice service	20% coinsurance	20% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery (subject to utilization review, covered only when performed at CME or BDCSC)
- Chiropractic care
- Coverage provided outside the United States. See www.BCBS.com/bluecardworldwide

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-888-8288. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross Blue Shield
Grievance and Appeals
21555 Oxnard Street
Woodlands Hills, CA 91367

Department of Labor's Employee Benefits Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform

California Department of Insurance
300 South Spring St.
Los Angeles, CA 90013
1-800-927-4357
www.insurance.ca.gov

Additionally, a consumer assistance program can help you file your appeal. Contact:

California Department of Managed Care
California Help Center
980 9th St., Suite 500
Sacramento, CA 95814-2725
1-888-466-2219
www.dmhc.ca.gov
www.healthhelp.ca.gov
helpline@dmhc.ca.gov

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,840
- **Patient pays** $700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$30
Coinsurance	$520
Limits or exclusions	$150
Total	**$700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,630
- **Patient pays** $770

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$550
Coinsurance	$140
Limits or exclusions	$80
Total	**$770**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.